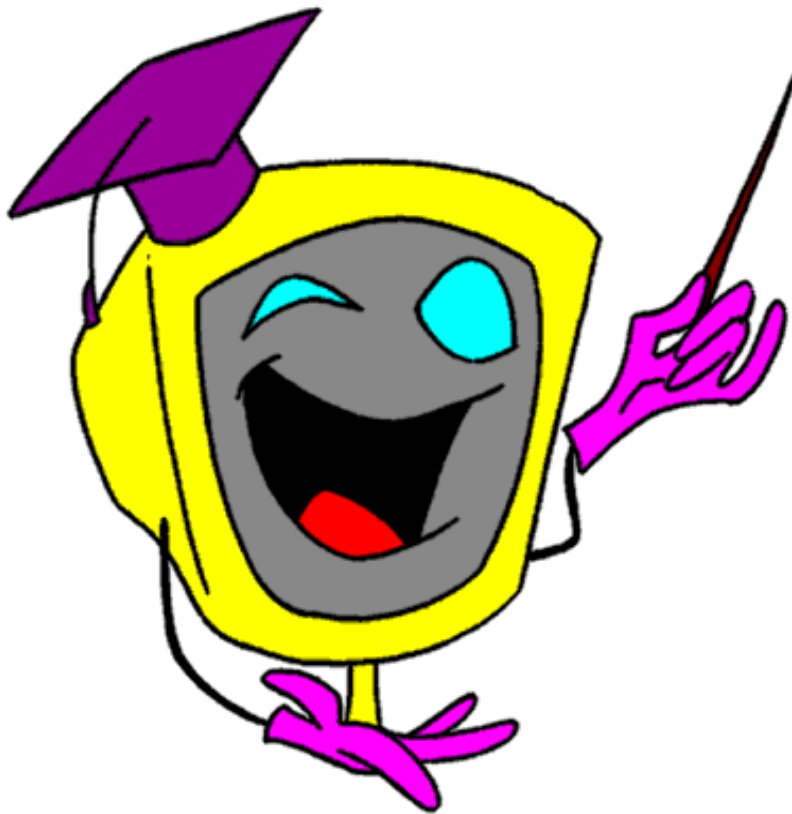


# Data Collection Guide



**Breast and Cervical  
Cancer Control Program  
2003**

**ProtectTexas™**  
Texas Department of Health



# Why collect data?

Public Law 101-354 amended by Women's Health Resource and Prevention Amendments of 1998 as Public Law 105-340 provides for breast and cervical cancer screening services in an effort to reduce mortality. The result of the law was the creation of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

The Texas Breast and Cervical Cancer Control Program (BCCCP) is funded by this program. In order to demonstrate the effectiveness of such a screening program, data collection is necessary. As a result, the NBCCEDP has established data collection as a program requirement.



The purpose of data collection is to provide feedback to the Centers for Disease Control and Prevention (CDC), the state office, and contractors on service delivery. Data is collected for each client until their screening cycle closes.

A **screening cycle** is the time period from the first screening exam until:

- Final diagnosis is reached or treatment is initiated.
- Client is lost to follow-up.
- Client refuses needed procedures.

## How is this data used?

Data collection allows programs to:

- Better understand the population served.
- Monitor trends in service delivery.
- Demonstrate program success.
- Identify needed improvements.
- Contribute to the growing body of knowledge about breast and cervical cancer.

Data also is used in:

- **Outreach:** Are you reaching your priority population? Are women at higher risk for developing breast and/or cervical cancer being reached?
- **Quality assurance:** Does service delivery occur within established timelines? Are program clients receiving appropriate services? Are results being received in a timely manner?
- **Case management:** Are BCCCP clients getting lost in the health care system? Are too many clients refusing services?

# BCCCP Data Collection Forms

## BREAST AND CERVICAL CANCER SCREENING FORMS (D-19B & D-19C)

These forms capture demographics, brief medical history, screening, and referral information. The D-19B is the data form used to collect breast cancer screening information and the D-19C is used to collect cervical cancer screening information.

- Breast cancer screening includes both a clinical breast examination and a mammogram. The clinical breast examination must be followed by a screening mammogram within sixty days.
- Cervical cancer screening includes a pelvic examination; Pap test; and a clinical breast examination.
- Contractors must initiate attempts to contact BCCCP clients of abnormal screening results within five (5) working days of their receipt.

## BREAST CANCER DIAGNOSTIC EVALUATION FORM (D-23)

## CERVICAL CANCER DIAGNOSTIC EVALUATION FORM (D-24)

These forms capture procedures, dates, results, funding source, testing location, diagnosis, and treatment status of diagnostic evaluation clients.

- Contractors must attempt to contact BCCCP clients of a positive (abnormal) diagnostic result within two (2) working days. If contact is not made within five (5) working days, the contractor must develop a plan of action based upon the severity of the results. The plan of action should occur as soon as possible, but not later than thirty (30) days of receipt of the abnormal finding.
- Diagnostic evaluation should be **completed within 60 days** of an abnormal screening.
- Treatment should be **initiated within 30 days** of a diagnosis of cancer.
- In addition, state office staff collects staging information for every diagnosis of cancer. See the BCCCP Manual of Operations for required staging documents.

**ALL CLIENTS SHOULD RECEIVE A CLINICAL BREAST EXAM**



## How often do I submit forms?

- Normal Screening: Submit data forms within 30 days of the screening result date (CBE/mammogram or Pap, whichever is later).
- Abnormal Screening with Follow-up: Submit data forms within 30 days of the final diagnosis or treatment status date, whichever is later.
- Submit forms *at least* once a month.
- Include a completed “Batch Control” sheet with all data form submissions. This sheet records the quantity of data forms being submitted. You may use the sheet the state office provides or develop one on your own with the same content.

## Where do I send forms?

Mark all submission packages containing client information “**Confidential.**” Data form submissions should be addressed to:

**Texas Department of Health  
Breast and Cervical Cancer Control Program  
1100 W. 49th Street, G-407  
Austin, Texas 78756**

**CONFIDENTIAL**

## What other BCCCP resources exist?

For additional information, the following **resources** are available:

- Breast and Cervical Cancer Control Program Manual of Operations.
- BCCCP Training Modules.
- Breast Health: A Guide for Screening Programs, Manual of Operations.
- Cervical Health: A Guide for Screening, Manual of Operations.
- Case Management: A Guide for Screening Programs, Manual of Operations.



## Obtaining Forms and Supplies

The AG-30, Requisition for Office Supplies/Forms/Literature form is to be used for obtaining most items needed for the BCCCP. Please reproduce the AG-30 form for your repeated use, a copy of the AG-30 form is provided on the next page. Below are items that may be ordered using the AG-30 form.

Item	Description	Obtain Thru	Order option: Phone/Fax #	Order option: On-line address
*M-47	State Cytology laboratory form (for Pap specimens)	Women's Health Lab	ph: 210/531-4596 fax: 210/531-4506	<a href="http://www.tdh.state.tx.us/mamd/litcat/default.asp">www.tdh.state.tx.us/mamd/litcat/default.asp</a>
*M-47	State Cytology laboratory form (for Pap specimens)	TDH Warehouse	ph: 512/458-7111	<a href="http://www.tdh.state.tx.us/mamd/litcat/default.asp">www.tdh.state.tx.us/mamd/litcat/default.asp</a>
Pap Supplies	Cytobrushes, slides, etc.	Women's Health Lab	ph: 210/531-4596;or 888/440-5002 fax: 210/531-4506	n/a
Pap Supplies	Cytobrushes, slides, etc.	TDH Pharmacy	ph: 512/458-7111 fax: 512/458-77489	n/a
B-13	State Purchase Vouchers (reimbursement requests)	BCCCP	ph: 800/452-1955 fax: 512/458-7650	n/a
Literature	BCCCP literature at no cost - catalog available	BCCCP	ph: 800/452-1955 fax: 512/458-7650	n/a

**\*The M-47 State Cytology Laboratory forms used with Pap specimens are designated for contractors using the State Laboratory (Texas Center for Infectious Diseases-TCID) only.** Contractors using private labs will need to obtain laboratory forms through the Pap facility utilized. However, *all* contractors, regardless of the lab they are using, may obtain Pap supplies through the Texas Department of Health (TDH) Pharmacy or Women's Health Lab by requesting them on the AG-30 order form. Contractors using TCID may also request mailing labels for Pap specimens on the AG-30 order form. For your reference, please note the customer service telephone number for the Women's Health Laboratories: (888) 440-5002 or (210) 531-4596.

To order supplies from the TDH Pharmacy complete the TDH AG-30 form by filling out the "quantity" and "description" columns and the "ship to address" box. Sign the form in the "authorized signature" box and the mail the AG-30 form to the Texas Department of Health, 1100 West 49<sup>th</sup> Street, Austin, Texas 78156, attention Pharmacy or fax to (512) 458-7489.

### BCCCP Data Forms

The state office distributes data forms every six months (March and September). The shipments are based on the average number of individual screens conducted over the last six months and prior use for each contractor. A percentage of extra forms are included to allow for growth in caseload. Prior to the distribution, state office staff will notify the appropriate contact person at the contractor's office of the estimated number of forms to be sent for their approval. Do not submit an AG-30 form to order data forms. Additional forms may be requested by telephone or e-mail at [www.tdh.state.tx.us/bcccp](http://www.tdh.state.tx.us/bcccp) any time during the year. The state office will ship data forms to the main contractor site.

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*(DATA FORM EXAMPLES)*

## SECTION ONE: BREAST AND CERVICAL CANCER SCREENING FORMS (D-19B, D-19C)

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### I. WHEN TO COMPLETE FORMS

A Breast and Cervical Cancer Screening Form should be initiated for every BCCCP client prior to receiving screening services. The forms are initiated by completing the Patient Information section, the Breast Cancer History section, and the Cervical Cancer History section at the top of the form. The rest of the form is completed as screening services are provided.



### II. WHERE TO SUBMIT FORMS

Each BCCCP contractor should send forms to the BCCCP state office **at least once every month**. Forms must be sent under **confidential cover** to the following address:

**Breast and Cervical Cancer Control Program  
Texas Department of Health  
1100 West 49th Street, G-407  
Austin, Texas 78756-3199**

**Confidential**

A copy of each screening and/or diagnostic form must be kept in the medical record of every woman who receives services through the BCCCP. The administrative office of each BCCCP contractor must have immediate access to a copy of every screening and/or diagnostic form upon request.

**SECTION ONE: BREAST AND CERVICAL CANCER SCREENING FORMS**  
**COMPLETION OF DATA COLLECTION FORMS**

---

**BREAST AND CERVICAL CANCER SCREENING FORMS**

**PLEASE PRINT**

Contractor No: _____	Clinic No: _____	Visit Date: ____/____/____	Chart No: _____	CD Number: _____
----------------------	------------------	----------------------------	-----------------	------------------

**CONTRACTOR NO.**

This is the **three digit identification number** assigned to each BCCCP contractor by the state office.

**CLINIC NO.**

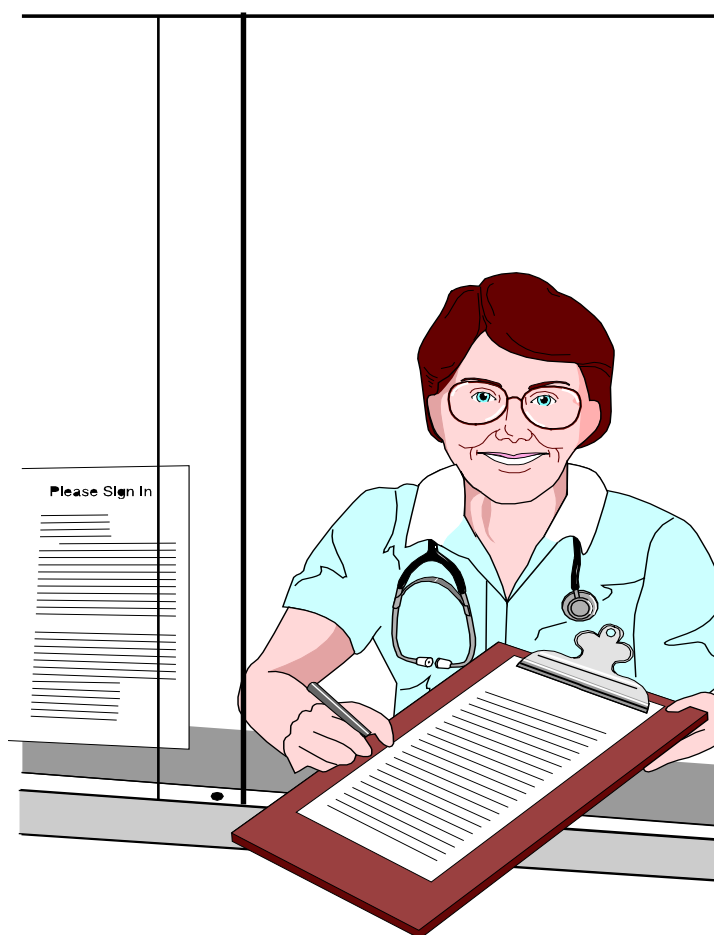
This is a **four digit identification number** to distinguish between individual clinic locations. (BCCCP contractors may provide services through many different clinic sites.) This number is assigned by the BCCCP contractor. If a client receives services at multiple clinic locations, this number should represent the clinic responsible for providing screening services.

**VISIT DATE**

This is the date of the first BCCCP-funded service reported on the form. If the client received screening services from a non-BCCCP funded source, it is the day the client met with the BCCCP contractor for diagnostic services. As with all dates on this form, the date should be written in the "mm/dd/yyyy" format, i.e. "February 15, 2003" is written in the format "02/15/2003."

**CHART NUMBER**

This is the chart number or medical record number or client ID number assigned by the clinic or BCCCP contractor. It may include up to ten (10) characters and contain letters, numbers, spaces, and dashes.



**SECTION ONE: BREAST AND CERVICAL CANCER SCREENING FORMS**  
**COMPLETION OF DATA COLLECTION FORMS (CONTINUED)**

**BREAST AND CERVICAL CANCER SCREENING FORMS**

**PLEASE PRINT**

Contractor No: _____	Clinic No: _____	Visit Date: ____/____/____	Chart No: _____	CD Number: _____
----------------------	------------------	----------------------------	-----------------	------------------

**CD NUMBER**

The CD Number is a nine digit number used to uniquely identify all clients served by the BCCCP. Please note the following:

- Clients are assigned one unique CD number upon enrollment into the program.
- Under no circumstances does a client's CD number change. Clients keep their originally assigned CD number through the life of the program (even if they transfer to another contractor within the BCCCP).
- CD numbers are unique to each client, therefore CD numbers may not be shared or duplicated.

BCCCP contractors are responsible for creating and assigning CD numbers. CD numbers are created according to the following rules:

1) The first three digits are the site number assigned to the BCCCP contractor. The provider number will always be 3 digits (include any leading zeros).

*For example, the first three digits of all CD numbers assigned by the provider whose site number is seven would be "007", not "7".*

2) The next two digits represent the calendar year in which the CD number is assigned. All clients enrolled on or after 1/1/2000 will have the letter "A" in the first position, and the number "0" in the second position. The "A" represents the new millennium and the "0" represents which year of the millennium.

*For example, for a client enrolled in the year 2000, their two digits for the calendar year would be "A0". A client enrolled in the year 2001, would enter "A1" in these two digits. For the year 2003 enrollees, it would be "A3", etc....*

3) The remaining four digits may be assigned by the contractor in any way desired. They must be in the range of 0001 through 9999. All four digits must be completed with numerals (letters, spaces, or dashes cannot be used).

*For example, in the year 2002, site 007 could assign valid CD numbers such as: 007 A2 0025, 007 A2 0103 and 007 A2 8914.*

The following would be **invalid** CD numbers:

- 7 A2 0200      leading zeros missing, making it a less than 9 digit CD#.
- 007 A2 025      one numeral missing in the last 4 digits, making it a less than 9 digit CD#.
- 007 A2 -123      no dashes allowed, numeral needed in its place.

**SECTION ONE: BREAST AND CERVICAL CANCER SCREENING FORMS**  
**PATIENT INFORMATION**

PATIENT INFORMATION					
Last	First MI		Maiden		Hispanic/Latino Origin <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Unknown  Race (mark all that apply) <input type="checkbox"/> 1 White <input type="checkbox"/> 2 Black/African American <input type="checkbox"/> 3 Asian <input type="checkbox"/> 4 Native Hawaiian/Pacific Islander <input type="checkbox"/> 5 American Indian/Alaskan Aleut <input type="checkbox"/> 6 Other <input type="checkbox"/> 7 Unknown _____ (Specify Other)
Address			Social Security Number ____/____/____		
City	State	Zip	Birth Date ____/____/____	Age	
Day Phone -	Night Phone -				

**LAST, FIRST, MI, MAIDEN**

**Print** the client's last name, first name, middle initial, and maiden name in the spaces provided. The last name is the client's current last name (or family name). The first name should be the client's full first name. Avoid nicknames and abbreviations. A client's maiden name is her family name prior to her first marriage.

**ADDRESS, CITY, STATE, ZIP**

Print the client's address, city, state, and zip code in the spaces provided. If the client does not maintain a permanent residence, any address where the client can receive mail should be recorded. The city name should be written without abbreviation. For the state, print the two-letter postal code (i.e., Texas is "TX"; for Mexico is "MX"). Write the client's zip code in the space provided, along with the four-digit extension, if known.

**SOCIAL SECURITY NUMBER**

Write the client's nine digit social security number in this space provided. If the client does not have a social security number, print **"NONE"** in this space-Do Not Leave Blank.

**BIRTH DATE, AGE**

Write the client's date of birth in this space using the format "mm/dd/yyyy." Write the client's age at the time of her visit.

**DAY PHONE**

Write a telephone number (if any) where the client can be reached during the day. **Be sure to include the area code.** The number can be the telephone number of the client's residence, work place, friend or relative.

**NIGHT PHONE**

Write a telephone number where the client can be reached after 6 pm. **Be sure to include the area code.** Like the day phone field, this can be the telephone number of the client's residence, work place, friend, or relative.

**RACE**

Indicate the client's race or ethnicity by checking **all appropriate boxes**. If none of the categories apply check the number six for "Other" and print the appropriate race in the space provided. If race is "Unknown" check number seven. If the client is multi-racial, you may mark multiple categories as appropriate.

## SECTION ONE:

BREAST CANCER SCREENING FORM  
BREAST CANCER HISTORY

BREAST CANCER HISTORY		
1. Has the client ever had a mammogram before?	Approximate Date: ____/____/____ (estimate if not sure)	
<input type="checkbox"/> 1 Yes →		
<input type="checkbox"/> 2 No		
2. Did breast symptoms lead to this visit?	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown
<input type="checkbox"/> 1 Yes		
3. Is this a short-term follow-up visit?		
<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
4. Has the client ever had breast cancer?	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown
<input type="checkbox"/> 1 Yes		
5. Does the client have a breast implant?	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown
<input type="checkbox"/> 1 Yes		

**1. Has the client ever had a mammogram before?**

If a client had a mammogram at any time prior to her current visit, check **"Yes"** and write the date of the most recent mammogram prior to the referring mammogram. If the exact date is unknown, please estimate or provide as much information as possible (i.e., "around 1975"). If a client has never had a mammogram before, or if a client is not sure if they have ever had a mammogram or a "breast x-ray," mark **"No."**

**2. Did breast symptoms lead to this visit?**

Mark **"Yes"** if:

- A client detected symptoms that resulted in seeking breast cancer screening services; **OR**
- If they were referred to this program by a medical professional because of possible symptoms for breast cancer; **OR**
- If they are receiving breast screening services before their regular annual or biannual visit.

**3. Is this a short term follow-up visit?**

If a client is returning for a short-term follow-up visit, mark **"Yes."** If client is returning for an annual or biannual visit, mark **"No."**

**4. Has the client ever had breast cancer?**

If a client has ever had breast cancer, mark **"Yes."** If they have never had breast cancer, mark **"No."** If the attending clinician is unsure whether or not a client has had breast cancer, mark **"Unknown."**

**5. Does The Client Have A Breast Implant?**

If the client has had breast reconstruction or cosmetic breast augmentation, or if they have had any other kind of breast implant that might interfere with a normal screening mammogram, mark **"Yes."**

**SECTION ONE: BREAST CANCER SCREENING FORM**  
**CLINICAL BREAST EXAM (CBE)**

---

CLINICAL BREAST EXAM (CBE)	
6.	Did the client receive a clinical breast exam this screening cycle? <input type="checkbox"/> 1 Yes <input type="checkbox"/> 3 No, other <input type="checkbox"/> 4 Yes, performed elsewhere
7.	If yes, when was the CBE performed?        /        /        .
8.	What were the results of this CBE? <input type="checkbox"/> 1 Normal/Benign findings ❖ <input type="checkbox"/> 2 Abnormal - Suspicious for cancer ❖ <i>Referral for case management and diagnostic procedures required</i>

**6. Did the client receive a clinical breast examination this screening cycle?**

Mark **"Yes"** if the client received a clinical breast examination (CBE) in the current screening cycle.

Mark **"No other"** if the client did not require a CBE this visit (ie. short term follow-up visit or referral).

Mark **"Yes, performed elsewhere"** if the client received a CBE elsewhere, within the past 30 days.

**Skip to question 9 if the client did not receive a CBE.**

**7. If yes, when was the CBE performed?**

Write the date on which the client received a CBE.

**8. What were the results of this CBE?**

Mark **"Normal/Benign findings"** if there were no indications that the client might have breast cancer. Benign findings such as fibrocystic changes, diffuse lumpiness, etc. should be included in this category. If the CBE revealed possible symptoms of breast cancer, such as a palpable mass, skin changes, or bloody nipple discharge, mark **"Abnormal- suspicious for cancer."**

*Note: Number 7 & 8 above must be answered even if the CBE was performed elsewhere.*

**SECTION ONE: BREAST CANCER SCREENING FORM**  
**INITIAL MAMMOGRAM**

---

INITIAL MAMMOGRAM	
9. Did the client receive a mammogram this screening cycle?	
1 Yes      3 No, other      4 Yes, performed elsewhere	
10. When was the mammogram performed?	____ / ____ / ____.
11. When were the results received?	____ / ____ / ____.
(Go to top of next column)	

**9. Did the client receive a screening mammogram this screening cycle?**

Mark **"Yes"** if the client received a screening mammogram funded through the BCCCP or an outside source for this screening cycle.

Mark **"No, other"** if the client is ineligible for a BCCCP funded mammogram, or if they do not need a screening mammogram this visit.

Mark **"Yes, performed elsewhere"** if the client received a mammogram elsewhere within the past 90 days.

**Skip to question 16 if the client did not receive a screening mammogram.**

**10. When was the mammogram performed?**

Write the date that the client received their screening mammogram.

**11. When were the mammogram results received?**

Write the date that the radiologist's report was received by the BCCCP provider.

*Note: Number 10 & 11 above must be answered even if the mammogram was performed elsewhere.*

**SECTION ONE:****BREAST CANCER SCREENING FORM  
INITIAL MAMMOGRAM (CONTINUED)**

INITIAL MAMMOGRAM (continued)	
12. Mammogram Type:	
<input type="checkbox"/> 76092 (Screen) <input type="checkbox"/> 76091 (Bilateral) <input type="checkbox"/> 76090 (Unilateral)	
13. What were the results of the initial mammogram?	
<input type="checkbox"/> 1	Negative
<input type="checkbox"/> 2	Benign
<input type="checkbox"/> 3	Probably benign
<input checked="" type="checkbox"/> 4	Suspicious
<input checked="" type="checkbox"/> 5	Highly suggestive of malignancy
<input checked="" type="checkbox"/> 6	Incomplete: needs additional imaging evaluation
<input checked="" type="checkbox"/> <i>Referral for case management and diagnostic procedures required</i>	
14. What was the funding source for the mammogram?	
<input type="checkbox"/> 1 CDC	<input type="checkbox"/> 2 Other _____
15. What radiology facility performed the mammogram?	
Facility _____.	
City _____ State _____ Zip _____.	

**12. What was the type of mammogram received?**

Mark the type of mammogram received. In the case of a short term follow-up requiring a diagnostic mammogram only and the diagnostic mammogram result is negative, the D-19B will be the only form required for documentation. If the diagnostic mammogram is abnormal and further testing is required or if the recommendation for short term follow-up is an ultrasound, a D-23 data form will also be needed to complete documentation.

**13. What were the results of the initial mammogram?**

Mark the mammogram results in one of the “overall assessment of findings” classification of the Final Mammography Quality Standards Act Regulations.

*See Appendix A for classifications.*

**SECTION ONE: BREAST AND CERVICAL CANCER SCREENING FORM**  
**INITIAL MAMMOGRAM (CONTINUED)**

---

INITIAL MAMMOGRAM (continued)
12. Mammogram Type: <input type="checkbox"/> 76092 (Screen) <input type="checkbox"/> 76091 (Bilateral) <input type="checkbox"/> 76090 (Unilateral)
13. What were the results of the screening mammogram? <input type="checkbox"/> 1 Negative <input type="checkbox"/> 2 Benign <input type="checkbox"/> 3 Probably benign <input type="checkbox"/> 4 Suspicious <input type="checkbox"/> 5 Highly suggestive of malignancy <input type="checkbox"/> 6 Incomplete: needs additional imaging evaluation  <i>❖ Referral for case management and diagnostic procedures required</i>
14. What was the funding source for the mammogram? <input type="checkbox"/> 1 CDC <input type="checkbox"/> 2 Other_____
15. What radiology facility performed the mammogram?  Facility _____  City_____ State _____ Zip_____.

**14. What was the funding source for the screening mammogram?**

- Mark "**CDC**" if this was a BCCCP-funded mammogram.
- If not, mark "**Other**" and specify the funding source (i.e., private insurance, gratis/donated, other funding source).

**15. What radiology facility performed the mammogram?**

Indicate the facility name, city, and zip code of the location where the mammogram was performed.

**SECTION ONE:****BREAST CANCER SCREENING FORM****BREAST CANCER SCREENING FOLLOW-UP STATUS**

---

FOLLOW-UP STATUS	
16. Was the client referred for case management and diagnostic procedures (dx mammogram/add'l views, ultrasound, breast biopsy, fine needle aspiration)?	
<input type="checkbox"/> 1 Yes → Date referred for procedure(s):	____/____/____.
(If yes, form D-23 <u>must</u> follow)	
<input type="checkbox"/> 2 No → Date of next breast screening:	____/____/____.
FOR STATE USE ONLY	

**16. Was the client referred for case management and diagnostic procedures (dx mammogram/add'l views, ultrasound, breast biopsy, fine needle aspiration)?**

Mark "Yes" if:

- The client was referred for case management and diagnostic procedure(s); **OR**
- The client was referred into the program for diagnostic procedure(s).

Write the date the client was referred for diagnostic procedures. Report the details of the diagnostic evaluation on the Breast Cancer Diagnostic Evaluation Form (D-23).

Mark "No" if:

- Cancer was not detected, client will return for next annual breast screening; **OR**
- Short term follow-up is recommended

Write the date of the client's next breast screening (this could either be her next annual screening, biannual screening; or a short term follow-up screening). The next screening date will initiate a new screening cycle and should be reported on a new Breast Cancer Screening Form (D-19B).

*For scanning legibility, the shaded area located at the bottom of the form is to remain blank for the state office date stamp.*

**SECTION ONE:**

**CERVICAL CANCER SCREENING FORM  
CERVICAL CANCER HISTORY**

CERVICAL CANCER HISTORY	
1.	Has the client ever had a Pap smear before? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>3</sub> Unknown  If yes, specify date and result:        /        /        .  <input type="checkbox"/> <sub>0</sub> Results not known <input type="checkbox"/> <sub>1</sub> Negative for intraepithelial lesion or malignancy <input type="checkbox"/> <sub>2</sub> Atypical squamous cells of undetermined significance (ASC-US) <input type="checkbox"/> <sub>3</sub> Low grade SIL (including HPV changes) <input type="checkbox"/> <sub>4</sub> Atypical squamous cells cannot exclude HSIL (ASC-H) <input type="checkbox"/> <sub>5</sub> High grade SIL (with features suspicious for invasion) <input type="checkbox"/> <sub>6</sub> Squamous cell carcinoma <input type="checkbox"/> <sub>7</sub> Abnormal glandular cells (including Atypical, Endocervical adenocarcinoma in situ and Adenocarcinoma) <input type="checkbox"/> <sub>8</sub> Other _____
2.	Has the client had a history of cervical dysplasia/cancer, HIV, HPV, or are they immuno-compromised? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>3</sub> Unknown
3.	Has the client had a hysterectomy? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>3</sub> Unknown
4.	If yes, was the hysterectomy performed for either cervical cancer or neoplasia? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>3</sub> Unknown

**1. Has the client ever had a Pap test before?**

If a client has ever had a Pap test at any time prior to her current visit, mark **"Yes"** and record the date and result of her most recent Pap test prior to the referring Pap test. If the exact date is unknown, please provide as much information as possible. If a client has never had a Pap test before, mark **"No."**

**2. Has the client had a history of cervical dysplasia/cancer, HIV, HPV or are they immuno-compromised?**

Mark **"Yes"** if a client has a medical history of cervical dysplasia, CIN I, CIN II, CIN III, CIS, cervical cancer, HPV, HIV, or if they are immuno-compromised.

Mark **"No"** if they have no history of cervical dysplasia, cervical cancer, HPV, or HIV.

Mark **"Unknown"** if the client is unsure whether they have ever had cervical dysplasia, cervical cancer, HPV, or HIV.

*(Questions 3 and 4 continued on page 13)*

**3. Has the client had a hysterectomy?**

Mark **"Yes"** if the client has ever had a complete or partial hysterectomy for any reason.

Mark **"No"** if a client has never had a hysterectomy.

Mark **"Unknown"** if the client is unsure if past medical history includes a hysterectomy.

**4. If yes, was the hysterectomy performed for either cervical cancer or neoplasia?**

Mark **"Yes"** if a client has had a hysterectomy, and the purpose was for cancer treatment.

Mark **"No"** if the hysterectomy was for some other purpose.

Mark **"Unknown"** if the purpose of the hysterectomy is unknown.

**SECTION ONE:****CERVICAL CANCER SCREENING FORM  
PAP TEST**

---

PAP SMEAR	
5. Was a CBE performed this visit?	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No (If CBE was abnormal, complete breast screening form)
6. Did the client receive a pelvic exam this screening cycle?	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No
7. Was the cervix present?	<input type="checkbox"/> 1 Yes (Cervical Pap) <input type="checkbox"/> 2 No (Vaginal Pap)
8. Did the client receive a Pap smear this screening cycle?	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 4 No, other <input type="checkbox"/> 2 Yes, performed elsewhere

**5. Was a CBE performed this visit?**

Mark **"Yes"** if the client received a clinical breast examination.

Mark **"No"** if they did not receive a clinical breast examination.

*If the clinical breast examination is abnormal, complete a breast cancer screening form (D-19).*

**6. Did the client receive a pelvic examination this screening cycle?**

Mark **"Yes"** if the client received a pelvic examination.

Mark **"No"** if the client did not receive a pelvic examination.

**7. Was the cervix present?**

Mark **"Yes"** if enough of the cervix was present to perform a cervical Pap test.

Mark **"No"** if the cervix was not present, necessitating a vaginal Pap test.

**8. Did the client receive a Pap test this screening cycle?**

Mark **"Yes"** if the client received a Pap test funded through the BCCCP or another source this screening cycle.

Mark **"Yes, performed elsewhere"** if the client received a Pap test elsewhere.

Mark **"No, other"** if a Pap test was not necessary.

**SECTION ONE:**

**CERVICAL CANCER SCREENING FORM  
PAP TEST (CONTINUED)**

PAP SMEAR (continued)	
9. Is this a short- term follow-up visit?	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No
10. When was the Pap smear performed?	____ / ____ / ____.
11. Specimen type for Pap test?	<input type="checkbox"/> 1 Conventional <input type="checkbox"/> 2 Liquid Based
12. When were the results received?	____ / ____ / ____.
13. What was the specimen adequacy of the Pap smear?	<input type="checkbox"/> 1 Satisfactory <input type="checkbox"/> 2 Unsatisfactory
14. Bethesda System used?	<input type="checkbox"/> 1 2001 <input type="checkbox"/> 2 1991
15. What were the results of the Pap smear?	<input type="checkbox"/> 1 Negative for intraepithelial lesion or malignancy <input type="checkbox"/> 2 Atypical squamous cells of undetermined significance (ASC-US) <input type="checkbox"/> 3 Low grade SIL (including HPV changes) <input checked="" type="checkbox"/> 4 Atypical squamous cells cannot exclude HSIL (ASC-H) <input checked="" type="checkbox"/> 5 High grade SIL (with features suspicious for invasion) <input checked="" type="checkbox"/> 6 Squamous cell carcinoma <input checked="" type="checkbox"/> 7 Abnormal glandular cells (including Atypical, Endocervical adenocarcinoma in situ and Adenocarcinoma)  <input type="checkbox"/> 8 Other _____  <input checked="" type="checkbox"/> <i>Referral for case management and diagnostic procedures required</i>
16. What was the funding source for the Pap smear?	<input type="checkbox"/> 1 CDC <input type="checkbox"/> 2 Other _____ <div style="text-align: right;">(specify)</div>
17. At what facility was the Pap smear specimen obtained?	Facility: _____ City: _____ State: _____ Zip: _____

*(Questions 9-17: Refer to the instructions on the next page for an explanation of each column.)*

**9. Is this a short-term follow up visit?**

If a client is returning for a short-term follow-up visit, mark **“Yes.”** If client is returning for an annual or biannual visit, mark **“No.”**

**10. When was the Pap test performed?**

Write the date the Pap test was performed.

**10. Specimen type for Pap test?**

Note if a conventional or liquid-based Pap was used.

**12. When were the results received?**

Write the date the Pap test results became available to the BCCCP provider. If the Pap test was performed elsewhere, record the date that the outside agency communicated the results to the provider.

**13. What was the specimen adequacy of the Pap test?**

This information is located on the cytopathology report from the laboratory. Unsatisfactory Pap tests are not reimbursable.

**14. Bethesda System Used?**

Note Bethesda System used for reporting Pap test results.

**15. What were the results of the Pap smear?**

Mark the results of the Pap test using the Bethesda classification system. If more than one classification applies, mark the highest. For example, if **"Negative for intraepithelial lesion or malignancy"** and **"Low grade SIL"** are noted, mark **"Low grade SIL."**

**16. What was the funding source for the Pap test?**

Mark **"CDC"** if this was a BCCCP-funded Pap test. If not, mark **"Other"** and specify the funding source for the Pap test (i.e., private insurance, donated, etc.).

**17. At what facility was the Pap test specimen obtained?**

Indicate the facility name, city, and zip code of the location where the Pap test was performed.

*Note: Number 10 thru 17 of this section should be answered even if the Pap test was performed elsewhere.*

**SECTION ONE:**

**CERVICAL CANCER SCREENING FORM**

**CERVICAL CANCER SCREENING FOLLOW-UP STATUS**

FOLLOW-UP STATUS
<p>18. Was the client referred for case management and diagnostic procedures (colposcopy, cervical biopsy, etc.)?</p> <p> <input type="checkbox"/> 1 Yes → Date referred for procedure(s): ____ / ____ / ____                <input type="checkbox"/> 2 No → Date of next cervical screening: ____ / ____ / ____         </p> <p style="margin-left: 40px;">(If yes, form D-24 <u>must</u> follow)</p>
FOR STATE USE ONLY

**18. Was the client referred for case management and diagnostic procedures (colposcopy, cervical biopsy, etc.)?**

Mark "Yes" if:

- The client was referred for case management and diagnostic procedure(s); **OR**
- The client was referred into the program for diagnostic procedure(s)

Write the date the client was referred for diagnostic evaluation. Report the details of the diagnostic evaluation on the Cervical Cancer Diagnostic Evaluation Form (D-24).

Mark "No" if:

- Cervical cancer was not detected, client will return for next annual/biannual screening; **OR**
- Short term follow-up is recommended

Write the date of the client's next cervical screening (this could be her next annual screening, or a short term follow-up screening). The next screening date will initiate a new screening cycle and should be reported on a new Cervical Cancer Screening Form (D-19C).

*For scanning legibility, the shaded area located at the bottom of the form is to remain blank for the state office date stamp.*

**ALL CERVICAL SCREENING REFERRALS  
REQUIRE A DIAGNOSTIC FORM (D-24)**



## **SECTION TWO: BREAST CANCER DIAGNOSTIC EVALUATION FORM (D-23)**

---

### **I. WHEN TO COMPLETE THIS FORM**

A Breast Cancer Diagnostic Evaluation Form is initiated upon referring a breast client for diagnostic treatment. This is designated at question #16 on the Breast Cancer Screening Form. The diagnostic form is to be completed as procedures are provided until a final diagnosis is reached. At that time, the form is completed and sent to the state office. The state office must receive the Breast Cancer Diagnostic Evaluation Form within 60 days of the referral date.



### **II. WHERE TO SUBMIT THIS FORM**

The submissions guidelines for the Breast Cancer Diagnostic Evaluation Form are the same as those for the Breast and Cervical Cancer Screening Form (refer to page *iii* in this manual).



**REMEMBER TO SUBMIT YOUR FORMS MONTHLY TO THE  
CENTRAL OFFICE UNDER CONFIDENTIAL COVER.**

**SECTION TWO: BREAST CANCER DIAGNOSTIC EVALUATION FORM**  
**PATIENT INFORMATION**

---

**BREAST CANCER DIAGNOSTIC EVALUATION FORM**

<b>Contractor No:</b> _____	<b>Clinic No:</b> _____	<b>Chart No:</b> _____	<b>CD Number:</b> _____		
<b>PATIENT INFORMATION</b>					
<b>Last</b>	<b>First</b>	<b>MI</b>	<b>Social Security Number</b> ____/____/____	<b>Birth Date</b> ____/____/____	<b>Age</b>

**PATIENT INFORMATION**

Write the contractor number, clinic number, chart number, CD number, client's name, social security number, date of birth, and age at the top of the form. This information can be obtained from the Breast Cancer Screening Form completed for the client.



**Don't Forget Her CD Number OR  
Your Contractor Number!!**

**SECTION TWO: BREAST CANCER DIAGNOSTIC EVALUATION FORM**  
**DIAGNOSTIC PROCEDURES**

DIAGNOSTIC PROCEDURES					
<b>1. Mammogram Type</b> <input type="checkbox"/> 1 Unilateral 76090 <input type="checkbox"/> 2 Bilateral 76091	<b>2. Ultrasound</b> <input type="checkbox"/> 76645	<b>3. Breast Biopsy</b> <input type="checkbox"/> Needle Core 19100 <input type="checkbox"/> Incisional 19101 <input type="checkbox"/> Excisional 19120 <input type="checkbox"/> With rad mkr 19125 <input type="checkbox"/> Add'l lesion 19126 <input type="checkbox"/> Preop Loc wire 19290	<b>4. Fine Needle/ Cyst Aspiration</b>  10021	<b>5. Physician Consultation</b> <input type="checkbox"/> 15 min 99241 <input type="checkbox"/> 30 min 99242 <input type="checkbox"/> 45 min 99243 <input type="checkbox"/> 60 min 99244 <i>Exam performed by surgeon/other breast specialist</i>	<b>6. Add'l Diagnostic Procedures <i>Without</i> Results</b> (mark all completed procedures)  <div style="text-align: right;">Date Performed</div> <div>Procedure /Fund Source</div> <input type="checkbox"/> Pre-operative ____/____/____  placement of (76096) localization wire <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other  <input type="checkbox"/> Surgical Pathology ____/____/____ (88305) <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other  <input type="checkbox"/> Anesthesia ____/____/____ (00400) <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other  <input type="checkbox"/> Stereotactic ____/____/____ Localization (76095) <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other  <b>Add'l Diagnostic Procedures <i>With</i> Results</b>  For each procedure listed below, Results: _____ Fund: <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other _____/____/____ CPT Code _____ Date _____ Results: _____ Fund: <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other
<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused	<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused	<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused	<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused	<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused	
<b>Date Performed</b> ____/____/____ _____ (Site)	<b>Date Performed</b> ____/____/____ _____ (Site)	<b>Date Performed</b> ____/____/____ _____ (Site)	<b>Date Performed</b> ____/____/____ _____ (Site)	<b>Date Performed</b> ____/____/____ _____ (Site)	
<b>Results Received</b> ____/____/____	<b>Results Received</b> ____/____/____	<b>Results Received</b> ____/____/____	<b>Results Received</b> ____/____/____	<b>Results Received</b> ____/____/____	
<b>Results:</b> <input type="checkbox"/> 1 Negative <input type="checkbox"/> 2 Benign <input type="checkbox"/> 3 Probably benign <input type="checkbox"/> 4 Suspicious <input type="checkbox"/> 5 Highly suggestive of malignancy <input type="checkbox"/> 6 Incomplete: needs add'l imaging evaluation	<b>Results:</b> <input type="checkbox"/> 1 Negative <input type="checkbox"/> 2 Cystic <input type="checkbox"/> 3 Solid <input type="checkbox"/> 4 Suspicious or Indeterminate	<b>Results:</b> <input type="checkbox"/> 1 Benign <input type="checkbox"/> 2 Malignant	<b>Results:</b> <input type="checkbox"/> 1 Normal <input type="checkbox"/> 2 Abnormal <input type="checkbox"/> 3 Indeterminate	<b>Results:</b> <input type="checkbox"/> 1 Normal <input type="checkbox"/> 2 Abnormal <input type="checkbox"/> 3 Other benign findings	
<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other	<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other	<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other	<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other	<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other	

(Questions 1-6: Refer to the instructions on the next page for an explanation of each column.)

## **Procedure**

- These columns are used for indicating the procedures a client receives.
- If a client receives a diagnostic procedure not listed, specify that procedure under column #6 “Additional Diagnostic Procedures”. Print the name of the procedure, the date performed and the five digit CPT (Current Physician's Terminology) code.
- If a client receives two of the same procedures, list one in its appropriate column and the other under column #6 “Additional Diagnostic Procedures.”

*See Appendix C for more information on breast cancer diagnostic procedure definitions.*

## **Procedure Status**

Mark “1” in the status column for each procedure that was performed.  
Mark “2” if the procedure is needed but has been refused by the client.

## **Date Performed/Site**

For each procedure that was performed (Status marked "1") write the date that the service was performed in this column. An optional line is provided to record the site where the service was performed.

## **Results Received**

Write the date that the provider received the results of the diagnostic procedure in this column. This date must be on or after the date performed.

## **Results**

Mark the appropriate diagnostic result for each procedure performed.

*Note: Diagnostic mammogram results should be indicated by using the overall final assessment classifications.*

## **Funding Source**

Mark "1" in this column if the procedure was funded by the CDC.

Mark "3" if the procedure was funded by some other source (donated, private insurance, other funding source).

**SECTION TWO:**

**BREAST CANCER DIAGNOSTIC EVALUATION FORM  
DIAGNOSTIC EVALUATION STATUS**

DIAGNOSTIC EVALUATION STATUS	
7. What date was the client referred for a diagnostic evaluation for possible breast cancer?	____/____/____
<i>NOTE: This date will match the date on the corresponding D-19B Screening Form (#16).</i>	
8. What is the status of the diagnostic evaluation?	
<input type="checkbox"/> 1 Evaluation complete; a final diagnosis has been reached	
<input type="checkbox"/> 2 Client refused needed procedures before a final diagnosis could be reached	
<input type="checkbox"/> 3 Client is lost to follow-up	
9. When was the evaluation completed (date of determining procedure), refused, or the client lost to follow-up? (see 8)	____/____/____
10. If the evaluation is complete, was breast cancer detected?	
<input type="checkbox"/> 1 Yes → (staging info required)	
<input type="checkbox"/> 2 No → specify next visit interval:	
_____ recommend short term follow-up	(skip to #14)
_____ recommend return to annual screening	(skip to #14)

**7. What date was the client referred for a diagnostic evaluation for possible breast cancer?**

Write the date that the client was referred for diagnostic procedures. This date must match the referral date under question # 16 of the Breast Cancer Screening Form.

**8. What is the status of the diagnostic evaluation?**

- **Evaluation complete:** Mark if a final diagnosis has been reached.
- **Client refused needed procedures before a final diagnosis could be reached:** Mark if a final diagnosis cannot be reached because a client refused needed procedures.
- **Client is lost to follow-up:** Mark if three attempts to contact the client have failed, with the third attempt being by certified mail.

*Refer to Appendix D for diagnostic evaluation status definitions.*

**SECTION TWO:**

**BREAST CANCER DIAGNOSTIC EVALUATION FORM  
DIAGNOSTIC EVALUATION STATUS (CONTINUED)**

DIAGNOSTIC EVALUATION STATUS	
7. What date was the client referred for a diagnostic evaluation for possible breast cancer?	____/____/____
<i>NOTE: This date will match the date on the corresponding D-19B Screening Form (#16).</i>	
8. What is the status of the diagnostic evaluation?	
<input type="checkbox"/> 1 Evaluation complete; a final diagnosis has been reached	
<input type="checkbox"/> 2 Client refused needed procedures before a final diagnosis could be reached	
<input type="checkbox"/> 3 Client is lost to follow-up	
9. When was the evaluation completed (date of determining procedure), refused, or the client lost to follow-up? (see 8)	____/____/____
10. If the evaluation is complete, was breast cancer detected?	
<input type="checkbox"/> 1 Yes → (staging info required)	
<input type="checkbox"/> 2 No → specify next visit interval:	
_____ recommend short term follow-up	(skip to #14)
_____ recommend return to annual screening	(skip to #14)

**9. When was the evaluation completed, refused, or the client lost to follow-up?**

If the evaluation is complete, write the date of determining procedure.

If the client refused needed procedures before a diagnosis could be made, write the date the client refused procedures.

If the client is lost to follow-up, write the date that you mailed the certified letter.

**10. If the evaluation is complete, was breast cancer detected?**

Mark "Yes" if question 9 is marked "Evaluation complete" and breast cancer was detected. Answer questions 11 through 13. *Staging information required.*

Mark "No" if breast cancer was not detected and specify next visit interval - then skip to question 14.

**SECTION TWO:**

**BREAST CANCER DIAGNOSTIC EVALUATION FORM  
BREAST CANCER TREATMENT STATUS**

BREAST CANCER TREATMENT STATUS	
COMPLETE #11 - #13 ONLY IF THE CLIENT IS DIAGNOSED WITH BREAST CANCER	
11. What is the treatment status for breast cancer?	
<input type="checkbox"/> 1 Treatment initiated or complete <input type="checkbox"/> 2 Client refused treatment <input type="checkbox"/> 3 Client is lost to follow-up <input type="checkbox"/> 4 Treatment scheduled or pending	
12. What date was treatment initiated, refused, or client lost to follow-up? (see 11)	____/____/____
13. Where was treatment initiated?	
Hospital/Facility: _____	
City: _____	Zip: _____
14. When is the client's next breast screening?	____/____/____

Answer questions 11 through 13 only if the client has breast cancer.

**11. What is the treatment status for breast cancer?**

- Mark "**Treatment initiated or complete**" if treatment for breast cancer has begun. This category may also be marked if the removal of the breast mass was considered treatment by the physician.
- Mark "**Client refused treatment**" if the client refused needed treatment.
- Mark "**Client is lost to follow-up**" if three attempts to contact the client have failed with the third attempt being by certified mail, if the client moved out of the state, or if the client died.
- Mark "**Treatment is scheduled or pending**" if breast cancer treatment is being arranged, but there will be a delay of 90 days or more before treatment actually begins.

*See Appendix E for treatment status definitions.*

**SECTION TWO:****BREAST CANCER DIAGNOSTIC EVALUATION FORM  
BREAST CANCER TREATMENT STATUS (CONTINUED)**

<b>BREAST CANCER TREATMENT STATUS</b>	
<b>COMPLETE #11 - #13 ONLY IF THE CLIENT IS DIAGNOSED WITH BREAST CANCER</b>	
<b>11. What is the treatment status for breast cancer?</b> <input type="checkbox"/> 1 Treatment initiated or complete <input type="checkbox"/> 2 Client refused treatment <input type="checkbox"/> 3 Client is lost to follow-up <input type="checkbox"/> 4 Treatment scheduled or pending	
<b>12. What date was treatment initiated, refused, or client lost to follow-up? (see 11)</b>	____/____/____
<b>13. Where was treatment initiated?</b>  Hospital/Facility: _____  City: _____ Zip: _____	
<b>14. When is the client's next breast screening?</b>	____/____/____
<b>FOR STATE USE ONLY</b>	

**12. What date was treatment initiated, refused, or the client lost to follow-up?**

Write the date the client began to receive breast cancer treatment (this might be the same as the biopsy date). If the client refused treatment, write the date the client refused treatment. If the client is lost to follow-up, record the date that certified letter was mailed.

*See Appendix E for treatment status definitions.*

**13. Where was treatment initiated?**

Document the name of the principal hospital or facility at which the client received breast cancer treatment. Document the name of the city and the zip code in which the hospital or facility is located.

**14. When is the client's next breast screening?**

Write the date of the client's next annual/biannual; or short-term follow-up visit.

*For scanning legibility, the shaded area located at the bottom of the form is to remain blank for the state office date stamp.*

## **SECTION THREE: CERVICAL CANCER DIAGNOSTIC EVALUATION FORM**

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### **I. WHEN TO COMPLETE THIS FORM**

A Cervical Cancer Diagnostic Evaluation Form is initiated upon referring a cervical client for diagnostic treatment. This is designated on question #18 on the Cervical Cancer Screening Form. The diagnostic form is to be completed as procedures are provided until a final diagnosis is reached. At that time, the form is completed and sent to the state office. The state office must receive the Cervical Cancer Diagnostic Evaluation Form within 60 days of the referral date.

### **II. WHERE TO SUBMIT THIS FORM**

The submission guidelines for the Cervical Cancer Diagnostic Evaluation Form are the same as those for the Breast and Cervical Cancer Screening Form (see page *iii*).



**SECTION THREE: CERVICAL CANCER DIAGNOSTIC EVALUATION FORM**  
**PATIENT INFORMATION**

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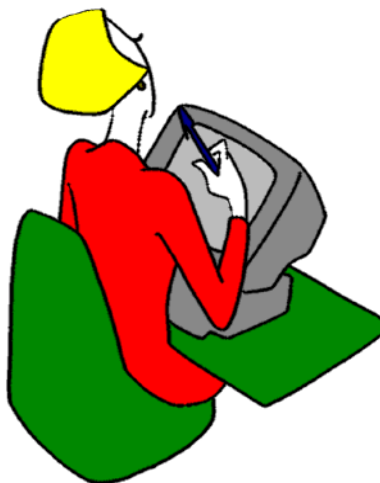
**CERVICAL CANCER DIAGNOSTIC EVALUATION FORM**

<b>Contractor No:</b> _____	<b>Clinic No:</b> _____	<b>Chart No:</b> _____	<b>CD Number:</b> _____		
<b>PATIENT INFORMATION</b>					
<b>Last</b>	<b>First</b>	<b>MI</b>	<b>Social Security Number</b> ____/____/____	<b>Birth Date</b> ____/____/____	<b>Age</b>

**PATIENT INFORMATION**

Write the contractor number, clinic number, chart number, CD number, client's name, social security number, date of birth; and age at the top of the form. This information can be obtained from the Cervical Screening Form.

**THE CD NUMBER ON THE DIAGNOSTIC EVALUATION FORM MUST BE THE SAME AS ON THE SCREENING FORM.**



## CERVICAL CANCER DIAGNOSTIC EVALUATION FORM

### DIAGNOSTIC PROCEDURES

DIAGNOSTIC PROCEDURES				
<b>1. Colposcopy Only</b>  <div>57452</div>	<b>2. Colposcopy &amp; Biopsy</b>  <div>57454</div>	<b>3. Other/CPT Code</b>  <div></div>	<b>4. Other/CPT Code</b>  <div></div>	<b>5. Other/CPT Code</b>  <div></div>
<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused	<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused	<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused	<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused	<b>Procedure Status:</b> <input type="checkbox"/> 1 performed <input type="checkbox"/> 2 refused
<b>Date Performed</b>  <div></div> <div></div> <div>(Site)</div>	<b>Date Performed</b>  <div></div> <div></div> <div>(Site)</div>	<b>Date Performed</b>  <div></div> <div></div> <div>(Site)</div>	<b>Date Performed</b>  <div></div> <div></div> <div>(Site)</div>	<b>Date Performed</b>  <div></div> <div></div> <div>(Site)</div>
<b>Results Received</b>  <div></div>	<b>Results Received</b>  <div></div>	<b>Results Received</b>  <div></div>	<b>Results Received</b>  <div></div>	<b>Results Received</b>  <div></div>
<b>Results:</b> <input type="checkbox"/> 1 Normal <input type="checkbox"/> 2 Abnormal	<b>Results:</b> <input type="checkbox"/> 1 Neg/Benign <input type="checkbox"/> 2 HPV/Atypia <input type="checkbox"/> 3 CIN I <input type="checkbox"/> 4 CIN II <input type="checkbox"/> 5 CIN III/CIS <input type="checkbox"/> 6 Invasive cancer <input type="checkbox"/> 7 Other	<b>Results:</b> <input type="checkbox"/> 1 Normal <input type="checkbox"/> 2 Abnormal <input type="checkbox"/> 3 Indeterminate <input type="checkbox"/> 4 Not Applicable	<b>Results:</b> <input type="checkbox"/> 1 Normal <input type="checkbox"/> 2 Abnormal <input type="checkbox"/> 3 Indeterminate <input type="checkbox"/> 4 Not Applicable	<b>Results:</b> <input type="checkbox"/> 1 Normal <input type="checkbox"/> 2 Abnormal <input type="checkbox"/> 3 Indeterminate <input type="checkbox"/> 4 Not Applicable
<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other	<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other	<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other	<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other	<b>Funding Source:</b> <input type="checkbox"/> 1 CDC <input type="checkbox"/> 3 Other

(Questions 1 – 5: Refer to the instructions on the next page for an explanation of each column.)

**SECTION THREE:                   CERVICAL CANCER DIAGNOSTIC EVALUATION FORM**  
**DIAGNOSTIC PROCEDURES (CONTINUED)**

---

**Procedure**

- These columns are used for indicating the procedures that a client receives.
- If a client receives diagnostic procedure(s) not listed, specify those procedure(s) under the “Other/CPT Code” columns (#3, #4, and #5). In the column heading, print the name of the procedure and the five digit Current Physician's Terminology (CPT) code underneath.
- If a client receives two of the same procedures, list one in its appropriate column and the second one under the ‘Other/CPT Code’ column.

*See Appendix F for cervical diagnostic procedure definitions.*

**Procedure Status**

Mark "1" in the status column for each procedure that was performed.  
Mark "2" if the procedure is needed but has been refused by the client.

**Date Performed/Site**

For each procedure that was performed (Status marked "1") write the date that the service was performed in this column. An optional line is provided to record the site where the service was performed.

**Results Received**

Write the date that the provider received the results of the diagnostic procedure in this column. This date must not come on or before the date performed.

**Results**

Mark the appropriate diagnostic result for each procedure performed.

**Funding Source**

Mark "1" in this column if the procedure was funded by the CDC.  
Mark "3" in this column if the procedure was funded by another source (donated, private insurance, other funding source).

DIAGNOSTIC EVALUATION STATUS	
7.	What date was the client referred for a diagnostic evaluation for possible cervical cancer? _____/_____/_____
<i>NOTE: This date will match the date on the corresponding D-19C Screening Form (#18).</i>	
8.	What is the status of the diagnostic evaluation? <input type="checkbox"/> 1 Evaluation complete; a final diagnosis has been reached <input type="checkbox"/> 2 Client refused needed procedures before a final diagnosis could be reached <input type="checkbox"/> 3 Client is lost to follow-up
9.	What date was the evaluation completed (date confirming procedure administered), refused, or the client lost to follow-up? (see 8) _____/_____/_____
10.	If the evaluation is complete, what is the final diagnosis? <input type="checkbox"/> 1 Normal/Benign Reaction/Inflammation <input type="checkbox"/> 2 HPV/Condylomata/Atypia <input type="checkbox"/> 3 CIN I/Mild Dysplasia <input type="checkbox"/> 4 CIN II/Moderate Dysplasia <input type="checkbox"/> 5 CIN III/Severe Dysplasia/Carcinoma in situ <input type="checkbox"/> 6 Invasive Cervical Carcinoma → (staging info required) <input type="checkbox"/> 7 Other_____

**7. What date was the client referred for a diagnostic evaluation for possible cervical cancer?**

Write the date that the client was referred for diagnostic procedures. This date must match the date under question #18 of the Cervical Cancer Screening Form.

**8. What is the status of the diagnostic evaluation?**

- **Evaluation complete:** Mark if a final diagnosis has been reached.
- **Client refused needed procedures before a final diagnosis could be reached:** Mark if a final diagnosis cannot be reached because a client refused needed procedures.
- **Client is lost to follow-up:** Mark if three attempts to contact the client have failed, with the third attempt being by certified mail.

**9. What date was the evaluation completed, refused, or the client lost to follow-up?**

- If the evaluation is complete, write the date of determining procedure.
- If the client refused needed procedures before a diagnosis could be made, write the date the client refused procedures.
- If the client is lost to follow-up, write the date that the certified letter was mailed.

See Appendix D for evaluation status definitions.

SECTION THREE: CERVICAL CANCER DIAGNOSTIC EVALUATION FORM  
DIAGNOSTIC EVALUATION STATUS (CONTINUED)

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DIAGNOSTIC EVALUATION STATUS
7. What date was the client referred for a diagnostic evaluation for possible cervical cancer?  _____ / _____ / _____
<i>NOTE: This date will match the date on the corresponding D-19C Screening Form (#18).</i>
8. What is the status of the diagnostic evaluation? <input type="checkbox"/> 1 Evaluation complete; a final diagnosis has been reached <input type="checkbox"/> 2 Client refused needed procedures before a final diagnosis could be reached <input type="checkbox"/> 3 Client is lost to follow-up
9. What date was the evaluation completed (date confirming procedure administered), refused, or the client lost to follow-up? (see 8)  _____ / _____ / _____
10. If the evaluation is complete, what is the final diagnosis? <input type="checkbox"/> 1 Normal/Benign Reaction/Inflammation <input type="checkbox"/> 2 HPV/Condylomata/Atypia <input type="checkbox"/> 3 CIN I/Mild Dysplasia <input type="checkbox"/> 4 CIN II/Moderate Dysplasia <input type="checkbox"/> 5 CIN III/Severe Dysplasia/Carcinoma in situ <input type="checkbox"/> 6 Invasive Cervical Carcinoma → (staging info required) <input type="checkbox"/> 7 Other _____

10. If the evaluation is complete, what is the final diagnosis?

Mark the final diagnosis using the categories provided.

- **Normal/Benign Reaction/Inflammation:**  
Mark if the client does not have cancer or a pre-cancerous condition.
- **HPV/Condylomata/Atypia:** "HPV" refers to human papillomavirus.
- **CIN I/Mild Dysplasia:** CIN means cervical intraepithelial neoplasia.
- **CIN II/Moderate Dysplasia**
- **CIN III/Severe Dysplasia/Carcinoma in situ:** Mark for "High Grade SIL".
- **Invasive Cervical Carcinoma:** Staging information required.
- **Other:** Specify any cancerous or pre-cancerous conditions that do not fit the above categories

If multiple categories apply, mark the most serious diagnosis. Do **not** specify treatment or diagnostic procedures in this space.

**SECTION THREE: CERVICAL CANCER DIAGNOSTIC EVALUATION FORM**  
**CERVICAL CANCER TREATMENT STATUS**

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CERVICAL CANCER TREATMENT STATUS	
COMPLETE THIS SECTION AFTER <u>ANY</u> FINAL DIAGNOSIS	
11. What is the treatment status? <input type="checkbox"/> 1 Treatment not needed <input type="checkbox"/> 2 Treatment initiated or complete <input type="checkbox"/> 3 Client refused treatment <input type="checkbox"/> 4 Client is lost to follow-up <input type="checkbox"/> 5 Treatment scheduled or pending	
12. What date was treatment initiated, refused, the client lost to follow-up, or a determination made that treatment was not needed? (see 11)	____/____/____
13. Where was treatment initiated? Hospital/Facility: _____	
City: _____	Zip: _____
14. When is the client's next cervical screening?	____/____/____

Answer questions 11 through 14 after any final diagnosis.

**11. What is the treatment status?**

- Mark "**Treatment not needed**" if the client's condition does not require treatment.
- Mark "**Treatment initiated or complete**" if any treatment has begun.
- Mark "**Client refused treatment**" if the client refused needed treatment.
- Mark "**Client is lost to follow-up**" if three attempts to contact the client have failed with the third attempt being by certified mail.
- Mark "**Treatment is scheduled or pending**" if treatment is being arranged, but there will be a delay of 90 days or more before treatment actually begins.

**12. What date was treatment initiated, refused, the client lost to follow-up, or a determination made that treatment was not needed?**

Write the date that the client began to receive treatment. If the client refused treatment, write the date the client refused treatment. If the client is lost to follow-up, write the date that the certified letter was mailed. If treatment was not needed, write the date of that determination.

*See Appendix E for treatment status definitions.*

**SECTION THREE: CERVICAL CANCER DIAGNOSTIC EVALUATION FORM  
CERVICAL CANCER TREATMENT STATUS (CONTINUED)**

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CERVICAL CANCER TREATMENT STATUS	
COMPLETE THIS SECTION AFTER <u>ANY</u> FINAL DIAGNOSIS	
11. What is the treatment status?	
<input type="checkbox"/> 1 Treatment not needed	
<input type="checkbox"/> 2 Treatment initiated or complete	
<input type="checkbox"/> 3 Client refused treatment	
<input type="checkbox"/> 4 Client is lost to follow-up	
<input type="checkbox"/> 5 Treatment scheduled or pending	
12. What date was treatment initiated, refused, the client lost to follow-up, or a determination made that treatment was not needed? ( <i>see 11</i> )	
_____ / _____ / _____	
13. Where was treatment initiated?	
Hospital/Facility: _____	
City: _____	Zip: _____
14. When is the client's next cervical screening?	
_____ / _____ / _____	

**13. Where was treatment initiated?**

Document the name of the principal hospital or facility at which the client received treatment. Document the name of the city and the zip code in which the hospital or facility is located.

**14. When is the client's next cervical screening?**

Write the date of the client's next annual/biannual; or short-term follow-up visit.

## **APPENDIX A: OVERALL ASSESSMENT OF FINDINGS CLASSIFICATIONS**

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### **Negative**

- There is nothing to comment on. The breasts are symmetrical and no masses, architectural disturbances, or suspicious calcifications are present.

### **Benign**

- This is also a negative mammogram, but the interpreter may wish to describe a finding. Involuting, calcified fibroadenomas, multiple secretory calcifications, fat containing lesions such as oil cysts, lipomas, galactoceles, and mixed density hamartomas all have characteristic appearances, and may be labeled with confidence. The interpreter might wish to describe intramammary lymph nodes, implants, etc. while still concluding that there is no mammographic evidence of malignancy.

### **Probably benign**

- A finding placed in this category should have a very high probability of being benign. It is not expected to change over the follow-up interval, but the radiologist would prefer to establish its stability. Data are becoming available that shed light on the efficacy of short interval follow-up. These will likely undergo future modification as more data accrue as to the validity of an approach, the interval required, and the type of findings that should be followed.

### **Suspicious**

- These are lesions that do not have the characteristic morphologies of breast cancer but have a definite probability of being malignant. The radiologist has sufficient concern to urge a biopsy. If possible, the relevant probabilities should be cited so that the patient and her physician can make the decision on the ultimate course of action.

### **Highly suggestive of malignancy**

- These lesions have a high probability of being cancer. Appropriate action should be taken.

### **Incomplete: needs additional imaging evaluation**

- This is almost always used in a screening situation and should rarely be used after a full imaging work up. A recommendation for additional evaluation should be made including the use of spot compression, magnification, special mammographic views, ultrasound, etc.
- Whenever possible, the present mammogram should be compared to previous studies. The radiologist should use judgment in how vigorously to pursue previous studies.

### **Unsatisfactory, film could not be interpreted by radiologist**

- Mammogram was technically flawed.

Source: Final Mammography Quality Standards Act (MQSA) Regulations: Effective April 28, 1999.

## **APPENDIX B:      BETHESDA CATEGORY DEFINITIONS**

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### **Negative (within normal limits)**

- There is nothing to comment on.

### **Atypical squamous cells (ASC)**

- ASC-US- atypical squamous cells of undetermined significance.
- ASC-H – atypical squamous cells of undetermined significance, cannot exclude HSIL.

### **Low grade SIL (including HPV changes)**

- Low-grade squamous intraepithelial lesion, encompassing: Cellular changes associated with HPV, mild (slight) dysplasia/cervical intraepithelial neoplasia grade 1 (CIN I).

### **High grade SIL**

- High-grade squamous intraepithelial lesion, encompassing: moderate dysplasia/CIN II, severe dysplasia/CIN III, carcinoma in situ/CIN III.

### **Squamous cell cancer**

- Invasive Cervical Carcinoma.

### **AGUS**

- Atypical endocervical, endometrial, or glandular cells.

Source: The Bethesda 2001 Reporting System for Pap Test Results

**Diagnostic Mammogram**

- **Unilateral Diagnostic Mammogram** - CPT 76090. Mammography of either the left or right breast.
- **Bilateral Diagnostic Mammogram** - CPT 76091. Mammography of both left and right breasts.
- Also includes the following descriptions: work up mammogram, spot compression, additional views of the breast via mammography, magnification views, compression views, cone compression, spot magnification.

**Ultrasound - CPT 76645**

- Echography of the breast(s), either unilateral or bilateral, B-scan and/or real time with image documentation.
- Ultrasound - CPT 76942. Ultrasonic guidance for needle biopsy, radiological supervision, and interpretation.
- Also includes: Sonogram and sonography.

**Breast Biopsy**

- Needle Core - CPT 19100. A needle used to sample a suspicious piece of breast tissue.
- Excisional - CPT 19120. Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion.
- Also includes: Lumpectomy, nodule removed, cyst removed, lump removed, removed mass (unless the breast is excised), excisional biopsy and biopsy.
- Incisional - CPT 19101. Different from excisional biopsy because the surgeon does not remove the entire mass.
- With radiological marker - CPT 19125. Metallic marker that shows up on x-ray to serve as landmarks or to identify areas of suspicion.
- Additional lesion - CPT 19126.
- Pre-opt. placement of local wire - CPT 19290.

**Fine Needle/Cyst Aspiration - CPT 88173**

- Fine needle aspiration with or without preparation of smears; superficial tissue, and fine needle biopsy.

**Office Consultation - CPT 99241**

- New or established patient office consultation which requires three key components: a) a problem focused history; b) problem focused examination; and c) straightforward medical decision making. Physician typically spends 15 minutes face-to face with patient. **For BCCCP purposes, an office consultation must include a breast exam by a surgeon or other breast specialist.**

**Office Consultation - CPT 99242**

- New and established patient office consultation which requires three key components: a) an expanded problem focused history; b) an expanded problem focused examination; and c) straightforward medical decision making. Physician typically spends 30 minutes face-to-face with patient.

**APPENDIX C (CONTINUED): PROCEDURES FOR THE BREAST CANCER DIAGNOSTIC EVALUATION FORM**

**Office Consultation - CPT 99243**

- New and established patient office consultation which requires three key components; a) a detailed history b) a detailed examination; and c) medical decision making of low complexity. Physician typically spends 40 minutes face-to face with patient.

**Office Consultation - CPT 99244**

- New and established patient office consultation which requires three key components; a) a comprehensive history; b) a comprehensive examination; and c) a medical decision making of moderate complexity. Physician typically spends 60 minutes face-to-face with patient.

**Additional Diagnostic Procedures**

- Can include but is not limited to: preoperative placement of needle localization wire, breast, CPT 76096, surgical pathology, CPT 88305, stereotactic localization, CPT 76095.

**DO NOT REPORT PRIVATE PHYSICIAN/CLINIC HOSPITAL; MASTECTOMY; OR TREATMENT INFORMATION AS DIAGNOSTIC PROCEDURES.**

## **APPENDIX D:      DIAGNOSTIC EVALUATION STATUS CATEGORY DEFINITIONS**

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### **Evaluation Complete**

- Diagnostic testing is completed, AND;
- The final diagnosis and date of final diagnosis are known.

### **Work-Up Refused**

- The client explicitly states that they will not consent to further diagnostic services.  
BCCCP recommends that the patient sign a refusal statement.

### **Lost To Follow-Up**

- Three documented attempts to contact the client to arrange diagnostic services have failed. These three attempts were by telephone, mail, or home visit, and the final attempt was by certified letter.

## **APPENDIX E: TREATMENT STATUS CATEGORY DEFINITIONS**

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### **Treatment Not Needed - Cervical diagnostic form only**

- The client does not have cervical cancer or severe cervical dysplasia; AND
- The client does not require immediate medical intervention.

### **Treatment Initiated or Completed - Both breast and cervical diagnostic forms**

- A written plan for the treatment of cancer or a precancerous lesion has been developed and started; AND
- Other obstacles to treatment have been identified and plans have been established to overcome them.

### **Treatment Refused - Both breast and cervical diagnostic forms**

- The client explicitly states that they will not consent to treatment for breast or cervical cancer or moderate to severe cervical dysplasia. BCCCP recommends that a signed refusal be obtained if possible.

### **Lost To Follow-Up - Both breast and cervical diagnostic forms**

- At least three documented attempts to contact the client to arrange cancer treatment services have failed. The three attempts were by telephone, mail, or home visit, and the final attempt was by certified letter.

**APPENDIX F: PROCEDURES FOR THE CERVICAL CANCER DIAGNOSTIC EVALUATION FORM**

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**Colposcopy Only - CPT 57452**

- Colposcopy (vaginoscopy); **without** biopsy

**Colposcopy and Biopsy - CPT 57454**

- Colposcopy (vaginoscopy) **with** biopsy(s) of the cervix
- The following terms also fit this category: endocervical curettage (ECC), biopsy, cervical biopsy.

**Additional Diagnostic Procedures**

- Can include but is not limited to: pathology CPT 88305, office visits CPT 99203, 99212, 99213, 99214
- Other procedures not funded by BCCCP: loop electrode excision procedure of the cervix (LEEP/LOOP) - CPT 57460. Conization of cervix (cold knife biopsy) - CPT 57520. Pelvic ultrasound - CPT 76856.

**DO NOT REPORT CRYOTHERAPY, CRYOSURGERY, MEDICATIONS FOR TREATMENT OF SYMPTOMS/DISEASE, BIOPSY UNRELATED TO CERVIX, LAPAROSCOPY, HYSTERECTOMY AS DIAGNOSTIC PROCEDURES.**

**APPENDIX G: INFORMATION REQUIRED FOR COMPLETION OF STAGING OF CANCERS**

**TMN**

- Tumor Node Metastasis completed and signed by a physician or Certified Tumor Registrar; or copies of the pathology and operative report submitted to the state office.

## BCCCP 2002-2003 Program Data Indicators

### Breast Indicators

1. Number of women served
2. Number of screening cycles
3. Percentage of eligible women aged 50-64 receiving CDC-funded mammograms
4. Percentage of screening mammograms that follow a CBE within 60 days
5. Percentage of abnormal mammograms/CBEs with a completed diagnosis <ul style="list-style-type: none"> <li>a. Percentage of diagnosis within 60 days of an abnormal screening</li> </ul>
6. Mean days between abnormal mammogram and final diagnosis
7. Mean days between diagnosis of breast cancer and treatment
8. Percentage of invasive or in-situ breast cancer with treatment initiated (include lost/refused) <ul style="list-style-type: none"> <li>a. Percentage of invasive or in-situ breast cancer cases that have treatment initiated within 30 days of diagnosis</li> </ul>
9. Percentage of breast cases closed*
10. Percentage of breast cancer cases staged*
11. Percentage of eligible women rescreened from previous year
12. Percentage of: <ul style="list-style-type: none"> <li>a. diagnostic evaluation reported lost to follow-up*</li> <li>b. treatment status reported lost to follow-up*</li> </ul>
13. Percentage of: <ul style="list-style-type: none"> <li>a. diagnostic evaluation reported as refused*</li> <li>b. treatment status reported as refused*</li> </ul>

\*cumulative data from program inception

## BCCCP 2002-2003 Program Data Indicator

### Cervical Indicators

1. Number of women served
2. Number of screening cycles
3. Percentage of abnormal Paps with a completed diagnosis a. Percentage of diagnoses reached within 60 days of abnormal screening (include lost/refused)
4. Percentage of >CIN II diagnosis with treatment initiated (include lost/refused) a. Percentage of >CIN II diagnosis with treatment initiated within 30 days
5. Mean days between abnormal Pap and final diagnosis
6. Mean days between >CIN II diagnosis and treatment
7. Percentage of cervical cases closed*
8. Percentage of invasive cervical cancer cases staged*
9. Percentage of: a. diagnostic evaluation reported lost to follow-up* b. treatment status reported lost to follow-up*
10. Percentage of: a. diagnostic evaluation reported as refused* b. treatment status reported as refused*

\*cumulative data from program inception

